PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, June 28, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Paul J. Cote, Jr., Commissioner, Department of Public Health, Mr. Manthala George, Jr., Mr. Albert Sherman (arrived late), Ms. Janet Slemenda, Dr. Thomas Sterne, Mr. Gaylord Thayer, Jr. and Dr. Martin Williams. Ms. Phyllis Cudmore and Ms. Maureen Pompeo were absent. Also in attendance was Atty. Donna Levin, General Counsel.

Commissioner Cote, Chair, announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Isabel Càceres, Epidemiologist, Research and Epidemiology Program, Center for Health Information, Statistics, Research, and Evaluation; Ms. Sally Fogerty, Associate Commissioner, Center for Community Health; Dr. Bruce Cohen, Co-Director, Center for Health Information, Statistics, Research, and Evaluation; Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control; Mr. Robert Walker, Director, Radiation Control Program; Mr. Jere Page, Senior Analyst, Determination of Need Program.

RECORDS:

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Records of the Public Health Council Meeting of April 19, 2005.

PERSONNEL ACTIONS:

In letters dated June 6, 2005, Val W. Slayton, MD, MPP, Chief Medical Officer, Tewksbury Hospital, Tewksbury, recommended approval of reappointments to the medical staff of Tewksbury Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with the recommendation of the Chief Medical Officer of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointments to the medical staff of Tewksbury Hospital be approved for the period of June 1, 2005 to June 1, 2007:

REAPPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Syed Rahman, MD	73277	Active Internal Medicine
Shala Asvadi, MD	52195	Consultant Dermatology
Khatija Gaffar, MD	53316	Active Internal Medicine
Lisa Price, MD	205404	Affiliate Psychiatry
Guillermo Walters, MD	74668	Consultant Radiology
Kevin Grimes, PhD	3945	Allied Psychology

In a letter dated June 13, 2005, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of appointments and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital be approved:

APPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Astrid Desrosiers, MD	78424	Consultant/Psychiatry
Negin Hajizadeh, MD	223022	Consultant/Internal Medicine
Thuy Le, MD	223856	Active/Internal Medicine
Meredith St. John	446	Allied Health Professional Licensed Acupuncturist
REAPPOINTMENTS:	**MASS. LICENSE NO.:**	**STATUS/SPECIALTY:**
Michael Gregory, MD	208255	Consultant/Internal Medicine
Michael Stephen, MD	218560	Consultant/Internal Medicine
George Whitelaw, MD	34608	Active/Orthopedic Surgery
Dennis Tyrell, Ph.D.	8124	Allied Health Professional/Psychology

STAFF PRESENTATION: "Massachusetts Deaths 2003", by Isabel Càceres, Epidemiologist, Research and Epidemiology Program, Center for Health Information, Statistics, Research, and Evaluation

Ms. Càceres made a slide presentation to the Council. Some statistical highlights follow:

- In 2003, there was a continued reduction in death rates for seven of the 10 leading causes of death. Declines were seen for heart disease, cancer, stroke, influenza and pneumonia, unintentional injuries, nephritis and septicemia. The reductions ranged from 0.4% to as much as 5% from 2002 rates. There was also a large decline of 24% in the homicide rate and a decline of 12% in the colorectal cancer death rate.

- In 2003, there were 226 Massachusetts residents who died from HIV/AIDS, the lowest number in MA (same as in 2000). However, the proportion of HIV/AIDS deaths among women has tripled since 1989 (34% vs. 11%), and the proportion of HIV/AIDS deaths for persons ages 45 and older has more than doubled since 1994 (50% vs. 20%).

- The infant mortality rate (IMR) was the second lowest in Massachusetts history. The IMR was 4.8 infant deaths per 1,000 live births, compared with 4.9 in 2002.

- Injuries were the leading cause of death for Massachusetts residents between the ages of 1 and 44 years.

- Life expectancy reached an all-time high. In 2003, a woman born in Massachusetts could expect to live to be 81, and a man, 76.

- Most cause-specific mortality rates are lower in Massachusetts than in the U.S., ranging from 8% lower for chronic lower respiratory disease (CLRD) to 69% lower for firearm deaths.

- There was an increase of 25% in the death rate from injuries of undetermined intent. The increase in this death rate was highest for black non-Hispanics (up 50%) and Hispanics (up 35%) since 2002.

- Deaths by poisoning, including drug overdoses, increased by 21% since 2002. The majority of poisoning deaths were due to narcotics and "other hallucinogens". This is consistent with national trends.

- As expected, most deaths occurred at older ages, but for Massachusetts, the largest number of deaths continues to be among the "oldest old" (people aged 85 and over). About 1 out of 3 deaths is to a person ages 85 or older (33%); almost 2 out of 3 deaths is to a person ages 75 and older (63%).

- Disparities by race, ethnicity, education and community persist:

    - The overall death rate for black non-Hispanics is 40% higher than the death rate for white non-Hispanics.

    - The death rate for those with a high school education or less was 3 times higher than the rate for those with 13 years of education or more.

        - New Bedford, Brockton, Springfield, Fall River and Lynn have the highest premature mortality rates among the state's 30 largest communities.

- Massachusetts either achieved or moved closer to most of the Healthy People 2010 mortality objectives. Out of 40 HP2010 mortality objectives examined, Massachusetts has achieved 16 targets and is within 25% of achieving targets for 8 indicators.

NO VOTE/INFORMATION ONLY

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO 105 CMR 130.000: HOSPITAL LICENSURE REGULATIONS GOVERNING MATERNAL AND NEWBORN SERVICES:

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, accompanied by Ms. Sally Fogerty, Associate Commissioner, Center for Community Health, presented the proposed amendments to 105 CMR 130.000 to the Council. Staff noted, "The proposed amendments update and clarify the current regulations and standardize the definitions and service requirements for the various levels of hospital maternal and newborn care. The amendments incorporate the principles of national recommendations of care modified to the Massachusetts health care system and recognize advances in clinical practice that support quality of care…There are over 80,000 births to Massachusetts residents each year. The current regulations for hospital maternal and newborn services were promulgated in 1989. Since that time, there has been a growth in both the knowledge and technology available to improve the outcomes for mothers, newborns and their families. In addition, there has been an increase in the number of community-based professional personnel who are trained in the maternal and newborn specialty fields, including neonatologists. The proposed amendments are designed to reflect evolving trends in maternal and newborn hospital care. The purpose of the amendments is to improve quality of care, to improve outcomes, to better serve families in the Commonwealth and to more efficiently provide services to mothers and newborns. The Department of Public Health licenses 51 hospitals to provide maternal and newborn care plus one freestanding children's hospital providing newborn intensive care. The proposed revisions will be applicable to these 52 hospitals."

SUMMARY OF KEY CHANGES PROPOSED:

Level of Care Requirements:

1. Gestational age added to definition of each level of service.

2. Maintains two categories of Level I service (IA and IB) and more clearly distinguishes services required for a level IB service designation, including constant availability of services 24 hours a day, 7 days a week.

3. Separates a Level II service into two categories: Level IIA and Level IIB. Level IIA similar to current II. Level IIB provides Continuous Positive Airway Pressure (CPAP) to newborns in accordance with Department guidelines. As an option, may also provide short term mechanical ventilation (STMV) for no more than 24 hours. Regulations added to support the added STMV services.

4. Establishes that designated Level III maternal and newborn service hospitals provide advanced subspecialty services for both mothers (Level III maternal service) and newborns (Neonatal Intensive Care Unit service).

5. Regulations added to promote breastfeeding practices and also limit open display of formula company marketing materials.

6. Updates infection control sections.

7. Updates physical plant requirements.

8. Enhances collaboration and transfer agreement sections.

Provider and Service Requirements:

9. Establishes higher levels of certification, education, and/or experience requirements for physicians, nurses, respiratory therapists, pharmacists and nutritionists in Level II and III services.

10. Includes Board certified or eligible family practitioner in Level IA service.

11. Requires 24-hour in-house obstetrician and neonatologist for Level III.

12. Requires a designated nurse educator at all levels.

13. Adds lactation care and services. Requires availability of International Board Certified Lactation Consultant (IBCLC) or equivalent.

Volume and Reporting Requirements:

14. Annual birth volume as a requirement for level designation:
    Level IA: No requirement for annual birth volume retained
    Level IB: Annual birth volume requirement eliminated
    Level IIA: 1,500 annual birth volume requirement maintained
    Level IIB: 2,000 annual birth volume requirement maintained
    Level III: Amended to add requirement of either an annual birth volume of 2000 or at least 10% of annual births are low birth weight infants (< 2,500 grams)

15. Patient-specific data reporting requirement added for hospitals of all levels.

Council Member Thayer, Jr. asked that informational materials be distributed to newborn mothers with information on the risks of secondhand smoke to their newborns. Associate Commissioner Fogerty said, "What we will do is add it to Section 130.615, the Patient or Family Services section, that would require distribution of written material and education around the dangers of secondhand smoke."

In conclusion, staff noted, "While the Department continues to recognize birth as a normal process and the value of family participation, the proposed amendments update and strengthen essential hospital components of maternal and newborn care. The Department intends to hold public comment hearings in several locations across the state on these amendments. Following the

hearings, we will return to the Public Health Council in the Fall of 2005 to provide a review of the testimony, to present any changes proposed in response to the testimony, and to request approval for final promulgation of the proposed amendments."

NO VOTE/INFORMATION ONLY

Informational Briefing on Proposed Amendments to 105 CMR 120.000, et seq.: Massachusetts Regulations for the Control of Radiation:

Robert Walker, Director, Radiation Control Program, accompanied by Atty. James Ballin, Deputy General Counsel, Office of the General Counsel, presented proposed regulations 105 CMR 120.000. He said in part, "The existing set of comprehensive regulations pertaining to the control and use of radioactive material and radiation in the Commonwealth was first drafted by the Radiation Control Program in March of 1994, and approved by the Public Health Council on February 24, 1995. These regulations were last amended on July 9, 1999. Promulgating these comprehensive regulations was a necessary precursor for Massachusetts to achieve Agreement State Status with the Nuclear Regulatory Commission (NRC). An Agreement State is one to which the NRC legally transfers authority to regulate possession and use of most types of radioactive materials based on the state's agreement to maintain a comprehensive Radiation Control Program and to promulgate regulations that are compatible with, and at least as restrictive as, the NRC regulations. Periodic revisions of the regulations are necessary to adopt new compatibility requirements imposed by the NRC."

Staff continued, "The primary purpose for the current proposed revisions is to adopt new requirements imposed by the NRC in its regulations regarding the medical use of byproduct material (10 CFR Part 35). The overall goals of the revisions are to implement NRC's regulations on those medical procedures that pose the highest risk to workers, patients, and the public, and to structure regulations to be more risk-informed and more performance-based. These revisions to the regulations are in 105 CMR 120.500. In addition, other sections of the regulations have been revised for compatibility and uniformity. These revisions are summarized as follows:

105 CMR 120.000: Generally

Minor edits and corrections have been made throughout the regulations to improve readability and clarify existing standards.

105 CMR 120.001: General Provisions

120.005: Additions and deletions for clarification in the Definitions Section, in particular the Radiation Protection Requirements

120.016(K): New Section – Enforcement Action for Deliberate Misconduct

105 CMR 120.100: Licensing of Radioactive Materials

120.122 (D): New Controls on Generally Licensed (GL) Devices
120.128 (D): New requirements for the distribution of GL Devices

120.125 (C): Adjustments in Financial Surety requirements
120.132 (E): Clarification of Decommissioning Funding Requirements
120.190 (C): Explicit recognition of areas in Massachusetts under exclusive Federal jurisdiction.

105 CMR 120.200: Standards for Protection Against Radiation

120.200: Minor Corrections, Clarifying Changes, and a Minor Policy Change
120.203: Radiation Protection Requirements: Amended Definitions and Criteria
120.233: Respiratory Protection and Controls to Restrict Internal Exposures
120.244-249 Radiological Criteria for License Termination
120.256: Low-Level Waste Shipment Manifest Information and Reporting

105 CMR 120.300: Radiation Safety Requirements for Industrial Radiographic Operations

Revision of the Industrial Radiographer Certification requirements

105 CMR 120.400: X-Rays in the Healing Arts

120.403: General requirements to strengthen quality control
120.405 (C): Fluoroscopic x-ray systems – Exposure rate limits

105 CMR 120.430: Therapeutic Radiation Machines

Minor revisions to align with revisions made to 120.500

Council Member Ms. Slemenda noted, "Next time you come before us, instead of a big packet, which we may or may not read, under each heading write a little one or two sentence summary which might help us who are not regulatory wizards." Council Member Dr. Sterne concurred. Council Member Mr. Thayer, Jr. asked, "What is the benefit to the Commonwealth in becoming an Agreement State?" Mr. Walker replied, "The benefit is that the licensees only have one regulatory agency to deal with. For instance, before 1997, medical institutions had to deal with two agencies. For the byproduct material that they used for medical treatment, they dealt with the Nuclear Regulatory Commission and for the accelerator produced radioactive material, they had to deal with us. They dealt with us for x-rays, which has no federal counterpart. It was mainly to have local control. The Department of Public Health in Massachusetts is closer to the issues in Massachusetts, and it is more fitting to have one agency rather than two." Mr. Thayer responded, "The belief is it is more efficient and less a burden on the people regulated to do it this way than it is not to be an Agreement State." "That's right", answered Mr. Walker.

No Vote/Information Only

Informational Briefing on Proposed Regulations to 105 CMR 152.000: Licensing of Residential Care Facilities:

Dr. Paul Dreyer, Associate Commissioner, Center for Assurance and Control, presented the proposed regulations 105 CMR 152.000 to the Council. He noted in part, "…These proposed regulations are based on the current requirements pertaining to facilities defined as Rest Homes in 105 CMR 150.000, Licensing of Long Term Care Facilities. These new regulations will create a set of regulations separate from licensure regulations for nursing facilities and specific to what will now be referred to as Residential Care Facilities (RCFs). The residential care facility provider community has advocated for many years for a more user-friendly, separate set of regulations. The proposed regulations were drafted by a work group including representatives of Massachusetts Association of Residential Care Homes (MARCH), Massachusetts Aging Services Association (MassAging), the American Red Cross, the Executive Office of Elder Affairs, and the Department's Divisions of Health Care Quality and Drug Control. The process began in 2002 with the following goals:

- Recognizing the changes in practice and technology
- Assure a consistent standard of practice in all residential care facilities
- Remove redundancies and confusing language
- Update references to other regulatory agencies where required.

The main changes in the proposed regulations include:

Section .001 Definitions:

- "Care Coordinator" has now replaced the term "Responsible Person". This person must be capable of supervising ancillary personnel.

- "Healthcare Provider" has been added and the term has been substituted throughout the document for the terms "physician or physician-nurse practitioner team or physician-physician assistant team".

Section.002 Administration:

- Administrator hours are based on the size of the facility and services provided.

- A minimum of specific topics to be addressed during employee orientation and training have been added.

- Consistent with recent changes to the licensure regulations for nursing facilities, requires at least one automated external defibrillator (AED), related policies and procedures, and a contract with a physician to act as the AED medical director.

Section .005 Medical Services:

- A resident must be seen by his/her Healthcare Provider every six months, unless the Healthcare Provider documents an alternative visit schedule. In all cases, a resident review shall be conducted at least annually. (An annual review at a minimum is not required in the current regulations.)

Section .006 Other Professional Services and Diagnostic Services:

- New language allows for self-administration of over-the-counter tests if authorized by the Healthcare Provider.

Section.007 Nursing and Personal Care Services:

- The facility must provide Care Coordinators according to a ratio based on the number of residents.

- The facility must provide an RN consultant (current regulations allow an LPN or RN) for a minimum of one-half hour/resident/month (current regulations require four hours/month/unit).

Section.008 Pharmaceutical Services and Medications:

- New language allows any oral, topical, eye and ear medications to be administered by a Care Coordinator who has been trained and certified in Medication Administration in accordance with Department policies and procedures, which will be modeled after the Medication Administration Program provided by the American Red Cross.

- New wording allows the facility to stock over-the counter drugs and medical supplies (current regulations limit these to what has been approved by the Department).

Section.011 Social Services and Mental Health Services:

- References to Community Support Residents and Services have been eliminated. Section B, "Assessment of Mental Health Needs", has been added. This section was developed in consultation with DMR and DMH.

Section.012 Activities and Recreation:

- The regulations require 20 hours of scheduled activity per week. Per unit (in the current regulations) has been eliminated.

Section.013 Clinical and Related Records:

- New language allows for password protected and secured electronically generated records. Printed versions must be immediately obtainable upon request and physical or electronic

backup copies must be obtained.

No Vote/Information Only

REGULATION:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO THE SUITABILITY REVIEW PROCESS HSA V PILOT PROJECT (105 CMR 153.022 (B))

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, presented the final amendments to 105 CMR 153.022 (B) to the Council. Dr. Dreyer noted in his memorandum of June 28, 2005 to the Council: "The proposed amendments will make permanent the suitability review HSA V project. The amendments were approved for emergency promulgation at the March 22, 2005 Public Health Council meeting so that there would be no lapse in the project, which was scheduled to expire on March 31, 2005. This project, established in February 1990, instituted a public notice and hearing process prior to transfers of ownership for long term care facilities located in HSA V. The project is part of the suitability review process for prospective owners/licensees of long term care facilities. Since 1990, 98 public notices of intent to acquire a long term facility in HSA V have been published. As a result of these notices, 32 hearings have been requested by residents of HSA V and conducted by the Department."

Dr. Dreyer further indicated, "The proposed amendments also add family councils to the hearing notification requirements. Recent amendments to the Massachusetts General Laws require nursing facilities to allow the formation of family councils. The proposed amendment to 105 CMR 153.022 (B)(2)(b) would require the current facility owner or licensee to notify a family council, if there is one, of any hearing scheduled regarding the transfer of ownership."

The Department conducted a public hearing on June 9, 2005. It was unattended. Written comments were accepted through June 20. The Department received written comments from the Massachusetts Extended Care Federation, Representative Stephen R. Canessa of the 12th Bristol District, Representative David M. Torrisi of the 14th Essex District, and the Massachusetts Advocates for Nursing Home Reform. No changes were made as a result of these comments.

In closing, Dr. Dreyer said, "Staff recommends that the amendments be promulgated as originally proposed."

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve the **Request for Final Promulgation of Amendments to the Suitability Review Process HSA V Pilot Project (105 CMR 153.022 (B))**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14,815**.

DETERMINATION OF NEED PROGRAM:

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DoN PROJECT NO. 4-3A80 OF BRIGHAM AND WOMEN'S HOSPITAL, INC.: REQUEST FOR A SIGNIFICANT CHANGE TO MODIFY A CONDITION OF APPROVAL RELATING TO PROJECT FINANCING:

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the modification request to a condition of approval of Project DoN No. 4-3A80 of Brigham and Women's Hospital. Mr. Page said in part, "This request is made pursuant to 105 CMR 100.753 of the Determination of Need Regulations for a significant change. The project has been approved for new construction of a ten-story (thirteen level) wing adjacent to the existing Hospital campus to increase the Hospital's adult medical/surgical, intensive care, and surgical capacity, add space for ancillary and ambulatory services, as well as replace and relocate existing medical/surgical and intensive care beds. The approved project also includes substantial renovation to decompress existing medical/surgical and intensive care beds to provide more patient privacy and increase necessary support space. The significant change seeks to modify a condition of project approval by changing the financing of the $208,527,190 (July 2004 dollars) approved maximum capital expenditure (MCE) from a 55% equity contribution to a 20% equity contribution. Significant Changes require the Council's action pursuant to 105 CMR 100.756 (G)."

Staff's analysis states:

"The Hospital states that all of the financing for its capital projects is undertaken by its parent, Partners HealthCare System, Inc. ("Partners") on a system-wide basis. Partners has historically raised funds through tax-exempt debt that is secured every two years, with the last such financing having been completed in 2003. The Hospital further states that at the time the DoN application was submitted in July 2004, the Hospital did not know how the system-wide borrowing in 2005 would affect this Project. Accordingly, the Hospital used financing projections that were based on its historical debt to equity ratio, consistent with condition of approval #3.

In connection with its planned 2005 tax-exempt financing, Partners has informed the Hospital that it wants to use long-term debt to finance the costs of projects with long useful lives, which is a prudent method for structuring its long term debt. As a result, Partners desires to use a greater portion of its long term debt to finance the costs of the Hospital's major capital expansion project. This will facilitate Partner's ability to use its various financing options to ensure more efficient and effective overall use of its resources. Accordingly, Partners has advised the Hospital that its plans to include a substantial portion of the MCE of the approved DoN project in Partner's 2005 tax-exempt debt financing. The requested change to allow the Hospital to provide a 20% equity contribution and finance the remaining 80% of the approved MCE will permit Partners to secure the necessary financing in the most appropriate manner and will not materially alter the financial feasibility or scope of the project."

In conclusion Staff said, "In reviewing the request for a change of the condition concerning project financing, Staff has examined whether the proposed financing of the MCE was reasonable in light of past decisions, was not foreseeable at the time the application was filed and was beyond the

Hospital's control. Consistent with the Council's past decisions, Staff finds that the proposed change in project financing was unforeseen at the time the application was filed, and therefore beyond the control of the Hospital. Staff recommends approval with conditions of the request by Brigham and Women's Hospital, Inc. for a significant change to modify the condition of approval relating to financing of approved DoN Project No. 4-3A80 for new construction of a ten-story (thirteen level) wing located at 70 Francis Street in Boston to increase medical/surgical, intensive care, and surgical capacity, add space for ancillary and ambulatory services, replace and relocate existing medical/surgical and intensive care beds."

A brief discussion ensued. Council Member Thayer asked why the Commonwealth is interested in the financing of such a project if no tax dollars will be used. Dr. Dreyer, Associate Commissioner, stated, "I think historically, a portion of hospital capital financing did evolve to Commonwealth taxpayers. When the DoN program was originally developed, it certainly mattered whether equity versus debt was being proposed because some of that debt would be picked up by Commonwealth taxpayers. Hospital financing has changed over the years. The DoN regulations have not. We actually are currently working on a project to revise the DoN regulations to make them more consistent with current reality. We will be bringing those back to the Council for consideration sometime in the future but I think that is the best we can answer your question. The regulations currently require that this issue be addressed procedurally, we have to do it, but whether the fact that there is a clear policy reason at this time, there may very well not be." Council Member Sherman inquired about Medicaid funds. Dr. Dreyer responded, "Medicaid pays for a portion of hospital inpatient care, but if you look at how the Medicaid rates are calculated, I think this variation in capital probably plays a small part, in the past it did play a larger part."

After consideration, upon motion made and duly seconded, it was voted: (Chair Cote, Mr. George, Mr. Sherman, Ms. Slemenda, Mr. Thayer, and Dr. Williams in favor; Dr. Sterne recused himself; Ms. Cudmore and Ms. Pompeo absent) to approve the **significant change (modify a condition of approval) of Previously Approved Project No. 4-3A80 of Brigham and Women's Hospital, Inc., Boston,** based on staff's analysis and recommendation noted above. The reason for this approval with conditions is that the amendment satisfies the Procedure for Significant Changes found at 105 CMR 100.756 of the DoN Regulations. The conditions accompanying this approval are as follows:

1. Brigham and Women's Hospital, Inc. shall contribute 20% in equity toward the final approved MCE of DoN Project No. 4-3A80.

2. All conditions attached to the original and amended DoN Project No. 4-3A80 shall remain in effect.

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The meeting adjourned at 10:50 a.m.

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Paul J. Cote, Jr., Chair

LMH/lmh